

The faces of death

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Authors' synopsis

The individual's reaction to imminent death depends on his concept of the existential meaning of death.

There are two main, but opposing, concepts, one positive and the other tragic. The first sees death as a transition to another mode of being. Within that three main modalities are to be distinguished, in which is considered either as an element in the cosmic harmony, the reintegration of the individual into the universal (the 'Tagorian' mode); or secondly the possibility of man's external existence through his transfer, together with his entire physical and psychological apparatus, to a realm of legend (the 'Mioritic' mode); or thirdly the culmination of life, the moment of maximum existential concentration overflowing into the universe and encircling it (the 'Rilkian' mode).

The second concept, the tragic concept, sees death either as a desired solution, which puts an end to the nothingness of life (the 'Tracklian' mode); or as a nonsense, as an absurd injustice of nature (the 'common' mode); or as a necessity of which we do not know the meaning, a dialectical moment of eternal change (the 'Stoic' mode).

The psychological care of the dying involves identification with the patient's concept of death, in order to maintain his morale and possibly diminish his terror of death. The doctor must therefore be a good psychologist and a genuine philosopher, in the strictest sense of the word.

Per tutti la morte ha uno sguardo. . . .

Cesare Pavese*

The psychological care of the dying is one of the most difficult tasks undertaken by the physician. There are two main reasons for this difficulty.

Firstly, death is man's most solitary experience. The moments when death is taking place are, for this reason, the least penetrable moments, psychologically speaking. These are the moments of supreme threat to the ego, which, at the moment of its own final denial by the cosmos, itself denies the whole world and asserts its own identity over and against the rest, considering itself defrauded of the immortality with which it must be endowed as a being.

*Death has one glance for every man. . . .

Secondly, this period of extreme existential concentration, the period prior to death, is also the moment of supreme meditative concentration on the value of life and death. The concept which arises out of such meditation is the result of the existential experience of the individual, and indissolubly blended with the many nuances of the concepts of life and death current in his social background.

In order that his care of the dying may be effective, the physician needs to gain access to the person's emotions at the very moment when the patient is least inclined to be open and penetrable; and, in addition, the doctor must identify himself with the psychological state of his patient and with his concept of death, thus enabling himself to act within that concept and reinforce the patient's positive attitudes, which may naturally tend to weaken at that time. In the case of the tragic concept of death (which is by far the most common) he must support the dying person during his effort of adaption to the imminence of his complete extinction.

It is imperative for the physician to be in communion with the dying at the deepest level, and to have complete empathy with his patient's vision of life and death. But, for the dying to accept the physician's participation with them at an effective level, he must gain their absolute trust, so that he may become for them a factor of central importance, capable on the one hand of acting as psychological catalyst in the transition to the last threshold and, on the other hand, of preserving their psychological and spiritual universe, thus prolonging the patient's life in that world which he is in the act of leaving.

Our experience with many types of dying people, especially with cancer patients, has led us to the conclusion that the multifarious concepts of death can be reduced to a few main forms, exemplified by each individual in a variety of nuances. The two main, but opposing concepts are:

- 1) The positive concept, which sees death as a cosmic complementarity, *ie*, a transition to another mode of being, to a new existential level.
- 2) The tragic concept, which sees death as an absolute end, a final interruption of individual existence, dissolution into an irreversible nothingness.

The positive concept

This covers anything from the obscure feeling of reincorporation of one form or another into the cosmos, to the well-defined philosophical consciousness of continuity after death.

This concept is that of people who, because of their social or personal, physical and/or spiritual experience, have had a long-standing communion with nature, which has favoured the development of a cosmic sentiment and a psychological harmonisation with nature's rhythms. Generally, these patients wish to die at home, as their birth-place has for them a unique ontological value, that is, the value of their preparation and regeneration in their own physical and effective universe.

Within the framework of this positive concept, three modalities are distinguishable:

- 1) *The 'Tagorian' mode*, which sees death as the return of the individual's existence to the boundless life of the cosmos: Man, as a finite being, is nothing less than a component of the cosmic harmony.
- 2) *The 'Mioritic' mode* is a Thracian concept with a particular nuance, expressed in the Romanian folk-ballad 'Miorita', famous in world literature. This ballad sees death as a possibility of giving man eternal existence through his transfer to a realm of legend and fairy-tale. Individual human existence, undiluted by cosmic life, is 'absolutised', together with the entire physical and psychological environment of its human existence.
- 3) *The 'Rilkian' mode*, which sees death as the culmination of life, the moment of maximum existential concentration overflowing into the universe and encircling it.

The tragic concept

This concept conceives of death as a total and irreversible extinction and recognises the following variations:

- 1) *The 'Traklian' mode*, the most sombre, sees death as a desirable solution which approximates to supreme delight and puts an end to the nothingness of life. Patients with this concept ask to die in hospital, not in order to get help, but because nothing and no one awaits them.
- 2) *The common mode* sees death as nonsensical, an

incomprehensible injustice, an immense fraudulent trick of nature. The dying man manifests a dramatic anxiety about death. But this type of patient takes refuge more readily in confused hopes of continued existence in the world after their death. They wish to die at home or to create something in their doctor's or relative's minds which will perpetuate their memory. The communion between physician and patient in these cases must be a psychological challenge.

3) *The 'Stoic' mode* sees death as a necessity of which the meaning escapes us, a dialectical moment of eternal change. For this reason, such people accept death with dignity and resignation. Sometimes an intense moment of enlightenment comes to these individuals after a long and active life and in their dying moments they have the feeling that they have reached the perfect completion of their mission.

From analysis of the above situations, it would seem that the physician's attempt to introduce himself into the most delicate and intimate moment of an individual's life does not stand much chance of success. To make the best use of the opportunities offered, the physician needs the ability to take the best advantage of even the most insignificant contacts offered by the dying person, which can assist him in access to that person's intimate psychology. Once he has been accepted, the physician must respond to the dying person's wishes with infinite tact and finesse, must respond to his concepts and pretexts in all their delicate shades of meaning, to create the feeling of a spiritual survival, or to bring illumination, or, at the very least, resignation. The dying person's cosmic feeling, his long experience of communion with nature and his life of intense activity are the three factors which facilitate the physician's difficult task.

The doctor who tries to care for a dying person must be a good psychologist and a genuine philosopher, in the strictest sense of the word. In this sphere any improvisation is disastrous. As the patient is in that uncertain zone between life and nothingness, the slightest psychological error can throw him off balance and send him into iatrogenic despair. In such circumstances the patient will reject the physician and may say, as Rilke did to his brother, who was also a doctor, 'I want to die my own death, and not my doctor's death.'